A. Business Office Workflow Diagrams

Contents

Registration - Centralized

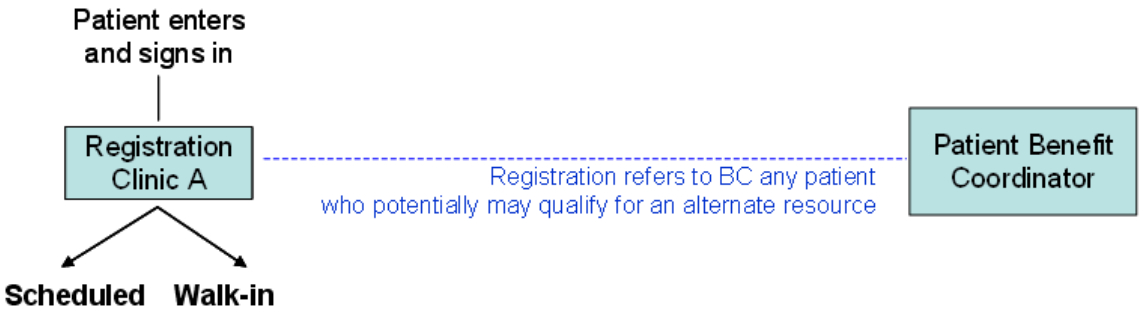


Figure 1: Centralized Registration process

Registration - Scheduled

- Verify patient appointments by telephone *the day before*
- For clinics with hard-copy medical records, *pull the night before*
- Update demographics, if changed
- Obtain necessary pre-authorizations or referrals
- Update and verify insurance monthly (includes medical, dental and/or pharmacy)
- Copy insurance card (both sides), if changed,
- Complete required forms, if needed
- Obtain all necessary signatures
- Update Registration package or PIMS
- Patient goes to designated clinic waiting room

Registration - Walk-In

- Triage screening
- View health summary (print copy or view on-line)
- Pull medical record if patient will be seen, or refer to appointment clerk to schedule appointment, or refer to Emergency Room
- Same registration process as listed under Scheduled patient

Patient Benefit Coordinator (BC)

- Perform an assessment to determine if patient qualifies for alternate resource(s)
- Assist with completion of paperwork
- Follow-up with patient or State
- Assist with completion of Medicare paperwork for Part B or D

Registration - Decentralized

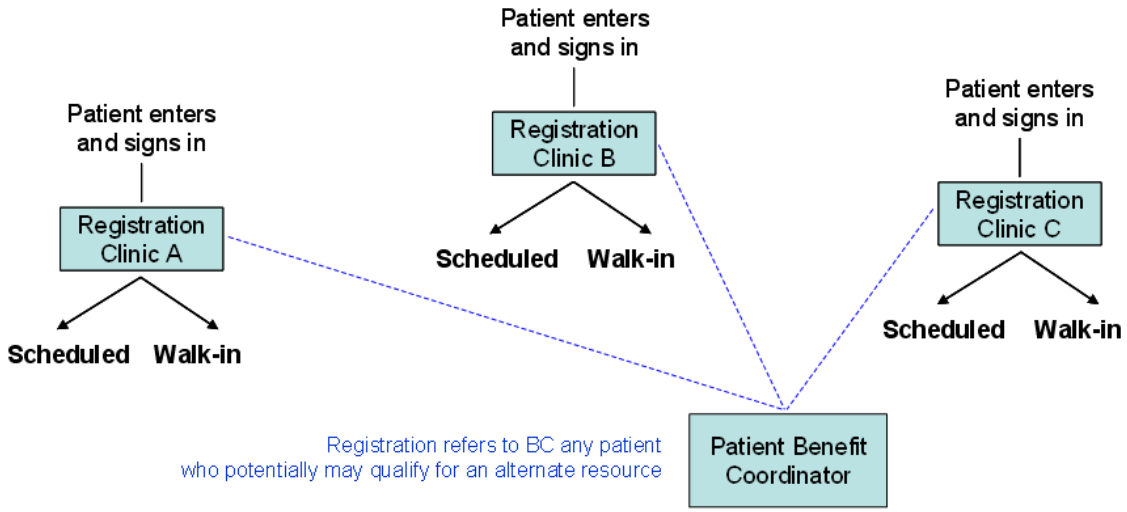


Figure 2: Decentralized Registration process

Note: All elements of the Registration process are duplicated at *each clinic* for Scheduled Appointments and Walk-Ins

Registration - Scheduled

- Verify patient appointments by telephone *the day before*
- For clinics with hard-copy medical records, *pull the night before*
- Update demographics, if changed
- Obtain necessary pre-authorizations or referrals
- Update and verify insurance monthly (includes medical, dental and/or pharmacy)
- Copy insurance card (both sides), if changed,
- Complete required forms, if needed
- Obtain all necessary signatures

- Update Registration package or PIMS
- Initiate printing of PCC+, if used at that clinic
- Patient goes to designated clinic waiting room

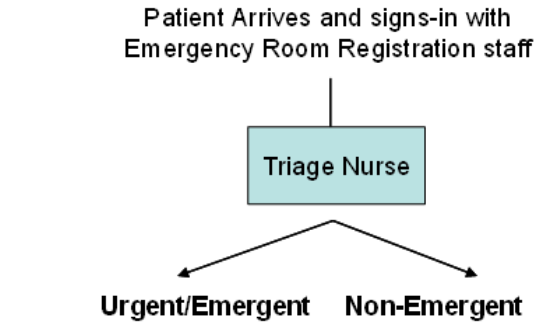
Registration - Walk-In

- Triage nurse screening and documentation
- View health summary (print copy or view on-line)
- Pull medical record if patient will be seen, or refer to appointment clerk to schedule appointment, or refer to Emergency Room
- Same registration process as listed under Scheduled patient

Patient Benefit Coordinator (BC)

- Coordinate referrals from each registration staff in the various clinics independently
- Perform an assessment to determine if patient qualifies for alternate resource(s)
- Assist with completion of paperwork
- Follow-up with patient or State
- Assist with completion of Medicare paperwork for Part B or D
- Update Registration package with ID number
- Update Notes on Page 9

Registration - Emergency Room



- Treated and released
  or
- Transfer to inpatient
  or
- Transfer to outside facility

Figure 3: Emergency Room (ER) Registration process

Note: For After Hours Care or if staff unavailable to enter updates to demographics and insurance, send patient to Registration staff.

Triage Nurse

- Prints or reviews online patient's health summary
- Completes triage and documents

Urgent/Emergent

- **Treated and released**
  - Proceed through registration process before leaving
  - Forward PCC or PCC+ to Billing office
- **Transfer to inpatient**
  - ER nurse notifies inpatient nurse of disposition of patient
  - Send Medical chart to inpatient
  - Registration goes to patient room to obtain insurance, demographic information
- **Transfer to outside facility**
  - ER Nurse completes transfer packet
  - Lab, x-ray, etc. results are copied for receiving facility
  - Print patient face sheet
  - Arrange transportation
  - Triage nurse documents visit on PCC or EHR
  - Registration for ER visit obtained from family

Non-Emergent

- Patient referred back to complete the full registration process prior to visit with provider

  -OR-

- Patient screened by provider and referred to clinic appointment clerk to schedule an appointment (e.g., prescription refill)

Note: If non-beneficiary patient, ER staff should collect payment before patient leaves.

Medicare 72-Hour Admit Business Process

Medicare patient is seen in the Emergency Room (ER) or outpatient clinic (OPD). The designated clerk checks dates on ER or OPD log with admission date.

Question: Has Medicare patient received any Outpatient (OP) services three (3) days prior to admission?

- If **Yes**,
  - Clerk checks OP and Inpatient document and conflicting charges exist
  - Registration documents for IP and OP are combined and taken to billing
  - Any other conflicting visits within 3-day window are consolidated
  - Biller documents note in RMPS system
  - Claim submitted to Medicare
- If **No**,
  - Note made in RPMS system that check was done
  - OP and/or inpatient claim proceed to Billing

Scheduled Admission

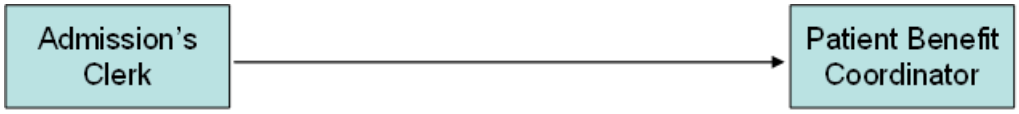


Figure 4: Scheduled Admission process

Admission's Clerk

- Notification received from Admitting
- Conduct phone interview with patient for demographic and billing information
- Inform patient of any pre-admission testing need - time and date
- Enter pre-admission information into RPMS System
- Verify insurance eligibility, by telephone or electronically, and enter into RPMS system
- Obtain Pre-Certification number, if needed
- Notify Patient Benefit Coordinator if insurance will not cover admission
- Obtain patient admit number or document control number
- Complete remainder of forms for admission, such as MSPs, advance directive, assignments, and others

Patient Benefit Coordinator

- Referral of patients without insurance to determine if patient qualifies for Medicaid
- Assist patient with the paperwork process
- Follow up with Medicaid to determine when coverage is effective
- Update RPMS Registration package with Medicaid number and effective date

Inpatient Admission

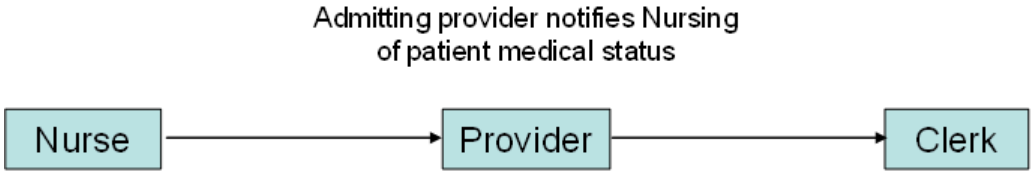


Figure 5: Inpatient Admission Process

Nurse

- Prepare room
- Order meals for patient, if applicable
- Patient brought to Inpatient department
- Update GPRA data, for example, tobacco use, alcohol, and such

Provider

- Write orders for patient

Clerk

- Transcribe order
- Contact dietary, if necessary
- Order labs or x-ray (STAT if needed)
- Notify Pharmacy of patient admit

Note: At **Discharge**

- Provider writes discharge orders and follow up instructions
- Pharmacy is notified of discharge orders and prepares any take home medications
- Case Management arranges for home health or DME as needed
- Discharge time entered in patient medical record
- Medical Records performs an analysis of health record

Prior to leaving facility, patient may be routed through Benefit Coordinator, if resources outstanding or MA process incomplete

Clinic

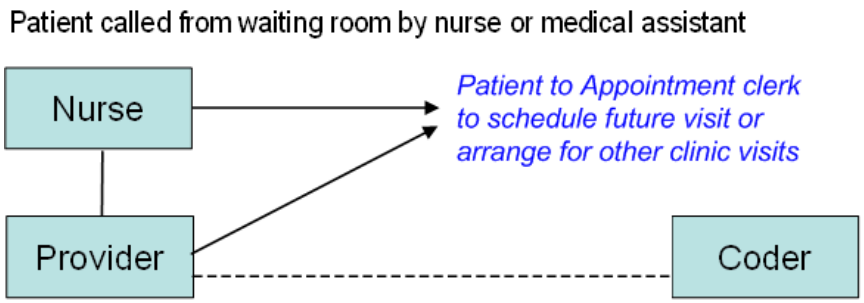


Figure 6: Clinic process

Nurse

- Obtain vitals and chief complaint
- Complete any standing orders or EKG, if needed
- Document information on PCC, PCC+, or EHR
- Update GPRA-related information

Provider

- Exam patient
- Order lab, x-ray, or pharmacy with symptom or diagnosis, manually or electronically; where
- Document note in PCC, PCC+, or EHR
- Code E&M and diagnosis(es) in PCC, PCC+, or EHR
- Return patient to nurse for further direction, additional testing, or education

Note: If lab, x-ray, or pharmacy ordered,

- Patient hand carries requisition to lab or x-ray, or request is sent electronically
- Staff hand carries medical record to pharmacy, or request is sent electronically

Coder

- Validate E&M and diagnosis coding of provider (Daily)
- Enter any additional coding data (Mnemonics, health factors, etc.) (Daily)
- Validate symptom or diagnosis for lab or x-ray
- Coordinate any discrepancies with provider

Billing

Note: Manual claims are sorted by insurer and sent with a cover sheet to the respective insurance company.

- Print Flagged Billable Report
- Review claims in Billing system for accuracy and completeness
- Toggle to EHR record, if needed, or query coder regarding question
- Review manual forms for accuracy
- Bill manually or electronically, depending on insurance
- Form working relationship with insurer
- Communicate coding or insurer policy changes to coder and provider
- Return discrepancies to coder or provider

Inpatient Billing

- Print all Admission sheets for previous day's admissions
- Print Admission and Discharge sheets, Census sheet, and Length of Stay reports
- Have Utilization Review, review admission
- After discharge, receive completed record from UR with notes that admission met approval criteria along with Certified Hospital form
- Re-verify Medicare eligibility and determine type of Medicare coverage
- Connect electronically and bill
- Input billing information
- Submit
- Return documents to UR for storage
- Obtain electronic report from Medicare as to whether admission approved, error in transmission, or rejected
- Look up claim transmittal number in written Medicare Admission log
- After any corrections on UB-92, re-bill Medicare electronically
- Receive Remittance Advice Report on claim from Medicare
- Billing complete

Account Reconciliation

- **PNC Bank -** Electronic deposit and hard copy Explanation of Benefits (EOB)
  - back to clinic

    -OR-
  - to Area office, which documents log and sends copy of EOB or Remittance Advice (RA) to clinic

    -OR-
- Hard copy EOB or RA, and hard copy check
  - back to clinic

    -OR-
  - to Area or Finance office, which deposits check and sends EOB or RA to clinic

Account Reconciliation

Note: As part of the check and balance process, checks must be verified and validated by Finance before depositing. Copies of checks must be maintained in Business and Finance offices. Check and RA or EOB are also copied, if both are being returned to the insurance company for refund.

- Receive and review Explanation of Benefits (EOB) or Remittance Advice (RA) for accuracy in payment and in correct clinic being paid
- Forward copies of rejections or inaccurately paid claims back to debt management for research
- For non-electronic posting, post each payment, adjustment and/or write-off to patient's account (includes all clinic and ancillary services)
- File EOB or RA when completed
- Return any EOB or RA paid for refunds, first to Finance and then to the insurer with a documented note

Business Operations Process Complete

45-Day-Old Claim Follow-up Cycle

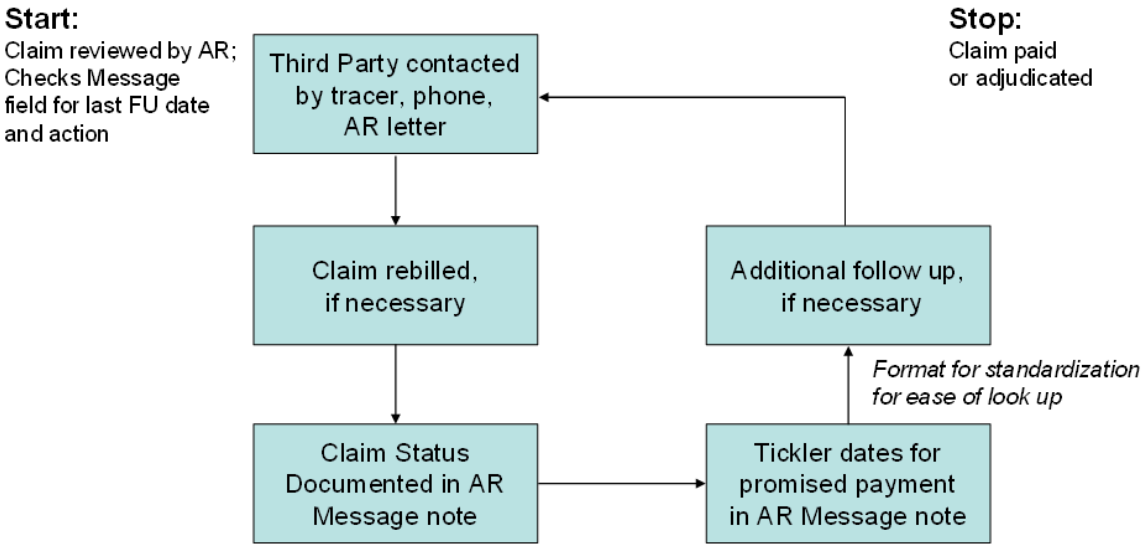


Figure 7: 45-Day-Old Claim Follow-up process

As illustrated in the figure, The claim is reviewed by AR, which checks the Message field for last FU date and action.

- The Third Party entity is contacted by tracer, phone, and/or AR letter.
- The claim is re-billed, if necessary.
- The claim status is documented in AR Message note.
- Tickler dates are set for promised payment in AR Message note.
- Additional follow-up is performed, if necessary.

The cycle stops when the claim is paid or adjudicated.

Laboratory (RPMS Lab Users)

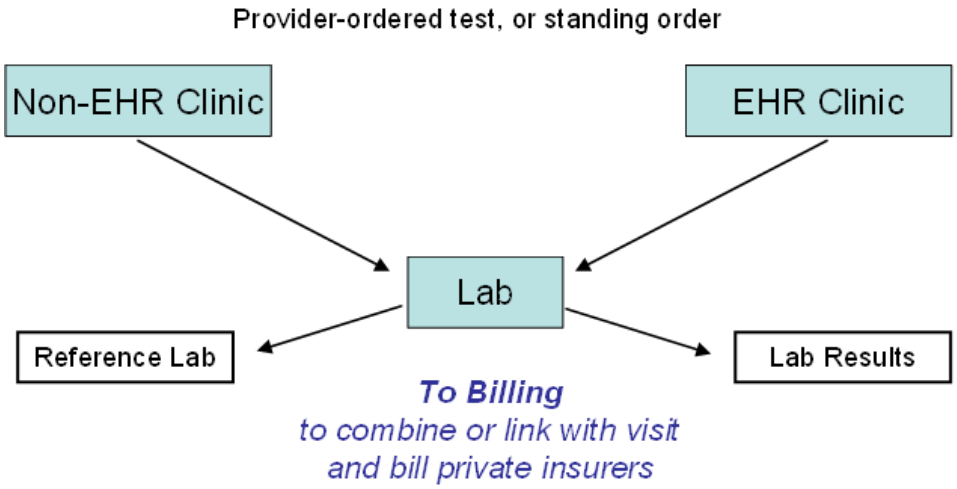


Figure 8: Laboratory (RPMS Lab users) Process

Non-EHR Clinic

- Requisition form completed by nurse that includes:
  - Codes and lab procedures
  - Reason for test
  - Provider name
  - Patient name
  - Date
  - Clinic name
- Patient hand carries to lab
- Lab places arrival time on requisition form
- Log information in Lab package

EHR Clinic

- Provider electronically enters order for test in EHR (diagnosis not entered, but is referenced in provider EHR note)
- Lab order prints in Lab

Lab

- Print labels and draws blood
- PCC form completed for lab when done on other than visit day

Reference Lab

- Send blood and copy of requisition to reference lab
- Results returned electronically
- Copy to provider to sign
- Results entered in RPMS
- Copy retained in medical record

Lab Results

- Results sent to provider to review and sign
- Enter data in Lab package
- Hard copy in Medical Record

Radiology

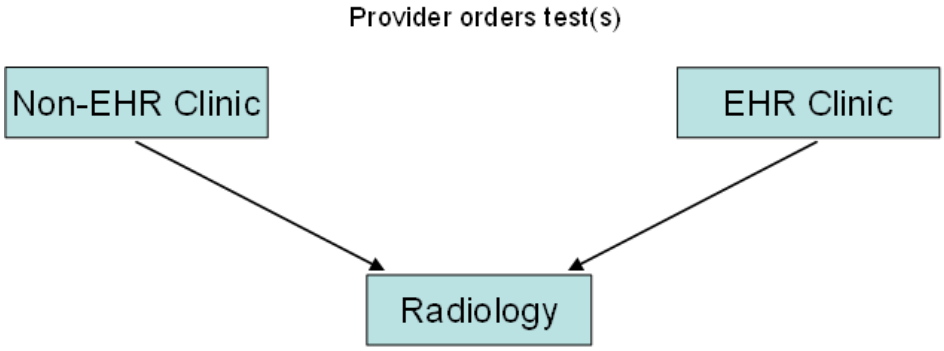


Figure 9: Radiology process

Non-EHR Clinic

- Data enter orders in Radiology package
- Radiology requisition filled out by Nursing to include:
  - Site (right or left, which
  - finger, etc.)
  - Reason for test
  - Provider's name
  - Patient name
  - Date
  - Clinic name
- Patient hand carries requisition to x-ray

EHR Clinic

- Electronic order entry with same information as non-EHR clinic requisition
- Radiology order prints in x-ray

Radiology

- Register patient in radiology package
- Enter CPT in RPMS, enter Radiology package details (room, views, type) and Case number issued
- Render test
- X-ray sent electronically or hand-carried to a hospital for interpretation, or read by a radiologist at the clinic for interpretation
- Interpretation immediately or within a couple of days, depending on process
- Electronic cut and paste into EHR
- All hard copy, provider signed final reports placed in patient's medical record
- Billing sent information on test as soon as completed – do not wait for interpretation to bill
- PCC form for radiology only test

Pharmacy - Non-EHR

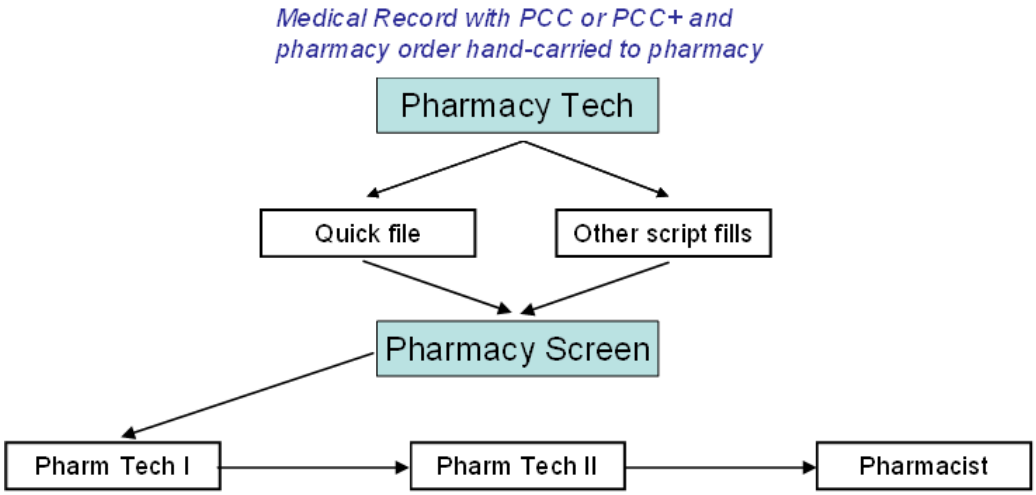


Figure 10: Pharmacy (Non-EHR) process

Pharmacy Tech

- Determine if patient can wait for script or pick up later
- Check to see if patient has insurance

Quick File

- Emergency Room
- Pediatrics
- Patients in pain

Other Script Fills

- Patients waiting for scripts
- Patients picking up script later or next day

Pharmacy Screen

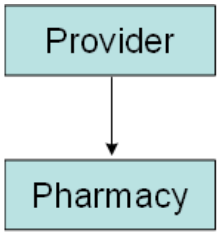
- Review previous visits and lab results in hard copy medical record
- Validate order and dosage from PCC/PCC+
- Check for drug-drug reactions
- Check for transcription errors

Pharm Tech 1: Type order into Point-of-Sale

Pharm Tech II: Fill script manually or use Script-Pro

Pharmacist: Dispense script, educate and council patients

Pharmacy - EHR



Provider

- Provider electronically orders pharmacy

Pharmacy

- Pharmacy order prints in pharmacy
- Pharmacy tech matches order with Electronic medical record
- Pharmacist reviews Current EHR provider note, previous medical notes, and lab results

Note: Remainder of EHR Pharmacy workflow is the same as Non-EHR, beginning with the Pharmacy Tech review.

Pharmacy Only

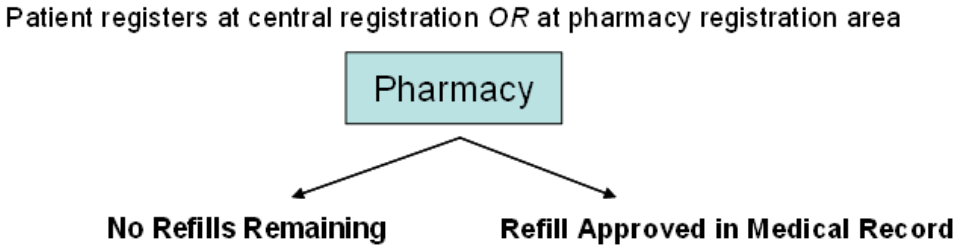


Figure 11: Pharmacy process

Pharmacy

- Pharmacist orders Medical Record to review script order

  -OR-

- Pharmacist reviews order on EHR

No Refills Remaining:

- Pharmacist contacts the provider, reviews the refill request with provider, *AND*
  - Obtains approval
    -OR-
  - Does not obtain approval and requests that patient make appointment with provider
- Pharmacist provides a couple-day supply and requests that patient make appointment with provider

Refill Approved in Medical Record:

- Pharmacist reviews Medical Record, lab results, other drugs being used, and fills script according to process in Pharmacy non-EHR workflow
- Pharmacist completes PCC with initials, or updates EHR record with script filled and electronic signature

For Billing pharmacy, see workflow diagrams in Pharmacy package

EHR and Point-of-Sale Billing

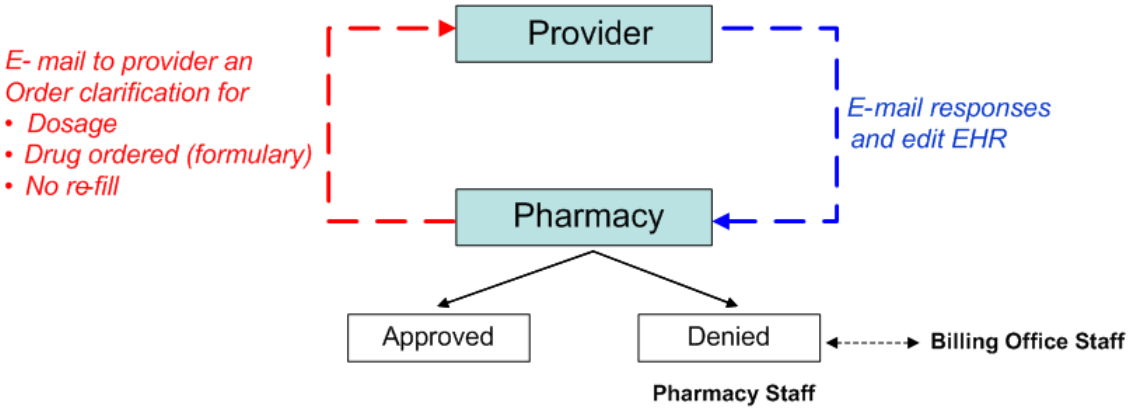


Figure 12: EHR and Point-of-Sale (POS) billing process

Provider

- Review prior medication list
- Enter Pharmacy orders electronically
- Responds to E-mail from Pharmacy for clarification on dosage, formulary, or no re-fill, and edits EHR.

Pharmacy

- Review new or renewed order (pharmacist, not pharmacy tech)
  - Assess incompatibilities
  - Assess dosage
- If necessary, E-mail provider an order clarification request for dosage, formulary, or re-fill status
- EHR toggle
  - Review lab results
  - Review prior pharmacy orders and prior lab results
- Enter POS, obtain eligibility, and bill

Approved Pharmacy Order:

- Fill script
- Page patient
- Counsel and educate
- Document note
- Dispense script

Denied Pharmacy Order:

- **Pharmacy Staff**
  - Correct and update system for pharmacy-related issues
  - Write-off all correct denials
- **Billing Office Staff**
  - Review pharmacy rejections related to insurance and update system
  - Back to Pharmacy to re-bill

Physical Therapy

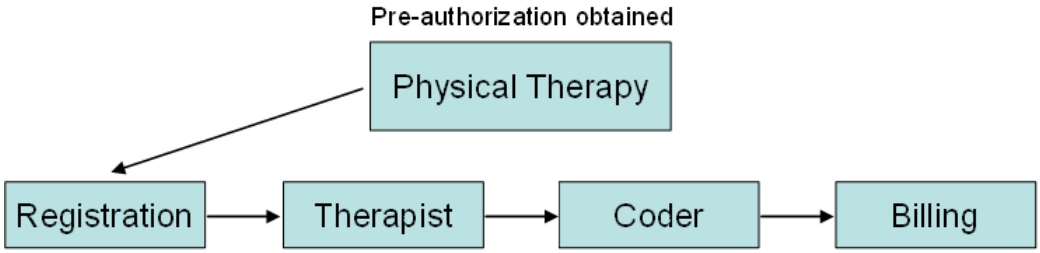


Figure 13: Physical Therapy process

Note: Physical Therapy (PT) occurs over a period of several weeks and usually, is billed weekly or at the end of treatment.

Physical Therapy

- Patient referred to PT by clinic provider or specialty provider group outside of clinic
- Patient schedules appointment with PT
- Patient presents

Registration

- Patient checks in at registration or directly at PT clinic (does not have to recheck at registration each visit)
- Patient updates demographic and insurance information only if update needed

Therapist

- Visit with patient
- Complete Plan of Care
- Complete PCC or PCC+ or superbill

- Retain Plan of Care and PCC, PCC+ or superbill in Medical Record
- Update each visits
- Submit copy to coding when therapy complete

Coder

- Review codes and/or code from PCC
- Query PT on any questions
- Enter data in RPMS system

Billing

- Review billable report
- Review coding
- Bill electronically or manually
- Follow up

Worker's Compensation

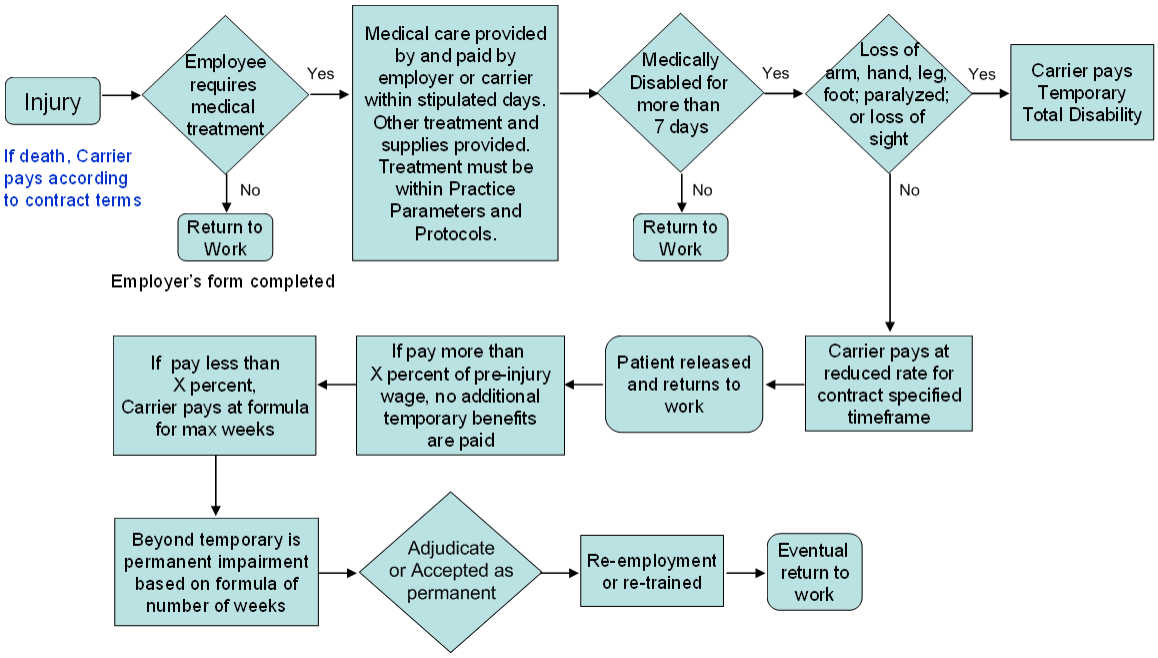


Figure 14: Worker's Compensation process

As illustrated in the figure, when an injury occurs at work and requires medical treatment, the medical care is provided by and paid by the employer

or insurance carrier within stipulated days. Other treatment and supplies are provided. Treatment must by within practice parameters and protocols.

If the worker is medically disabled for more than seven (7) days

- and there is a loss of arm, hand, leg, foot, or worker is paralyzed, or there is a loss of sight, the insurance carrier pays temporary or total disability.
- but no loss of arm, hand, leg, foot, or no paralysis, or no loss of sight, the insurance carrier pays at a reduced rate for contract specified timeframe. The patient is released and returns to work.

  If pay is
  - more than X percent of pre-injury wage, no additional temporary benefits are paid.
  - less than X percent, the insurance carrier pays at formula for maximum number of weeks.

Beyond temporary disability is permanent impairment, based on formula of number of weeks. The disability is adjudicated or accepted as permanent. The worker may be re-employed or re-trained for eventual return to work.

Behavioral Health

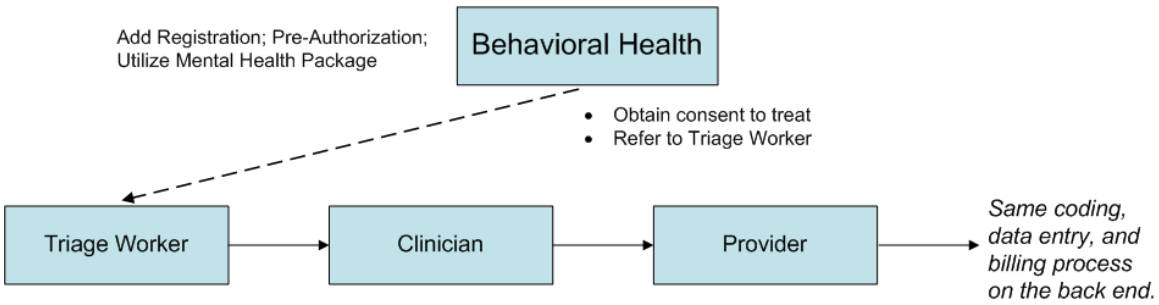


Figure 15: Behavioral Health process

Triage Worker

- Screen patient and determine patient needs
- Refer patient to clinician

Clinician

- Perform registration process for demographics, if not updated, and insurance, to determine if patient has coverage for behavioral health services
- Appointment scheduled and intake form completed

- Refills, meds issued, if necessary
- Schedule follow up visit or hospitalize patient, if medically necessary

Provider

- Visit with patient
- Complete PCC or EHR
- Document codes for visit and diagnosis on PCC or EHR
- Send patient to pharmacy if meds needed

Note: It is recommended that coding and data entry for behavioral be done by the staff in the Behavioral Department, to maintain confidentiality and privacy.

Optometry

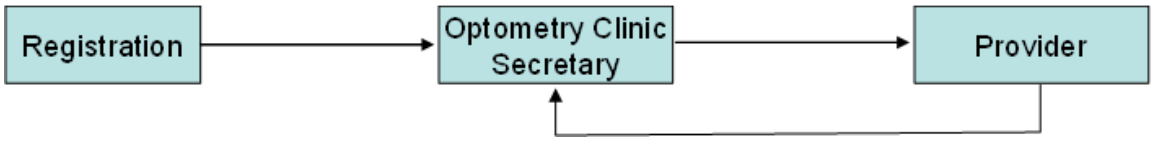


Figure 16: Optometry process

Registration

- Registration update performed at Central Registration *or* by Registration staff in Optometry department
- Medical record sent to Optometry clinic with PCC or PCC+ form
  -or-
  Send patient to Optometry clinic and use EHR

Optometry Clinic Secretary

- Check in patient and place patient in queue
- Call patient to exam room

Provider

- Complete exam
- Complete documentation on PCC, PCC+, or EHR
- Code visit, service, and diagnosis
- Technician orders lenses

Optometry Clinic Secretary

- Schedule follow up visit
- Schedule consults
- Schedule surgery
- Enter all codes

Note: Due to the uniqueness of this clinic, it is recommended that all coding and data entry occur within the clinic.

Accounts Receivable

Bill and follow up on any rejections or outstanding accounts

Pediatric

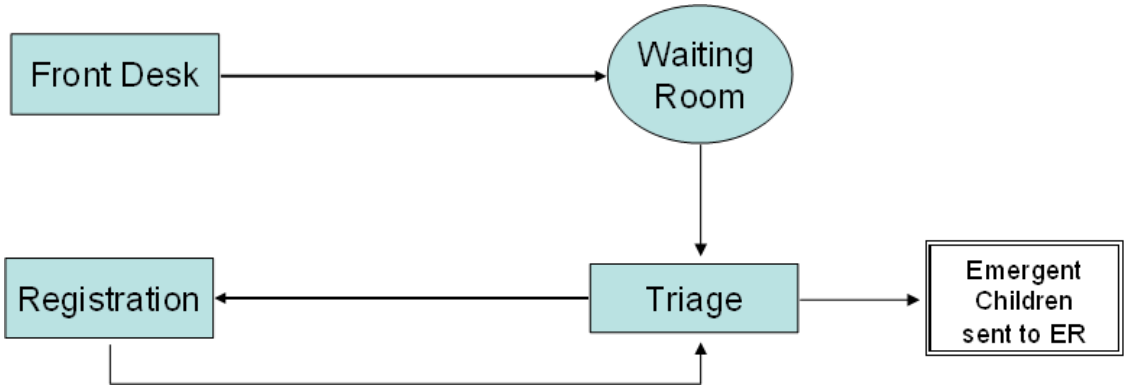


Figure 17: Pediatric process

Front Desk

- Walk-in or scheduled patient signs in
- Match medical record with PCC+ for scheduled patients
- If EHR, provide Triage nurse with list and Medical Record number

Triage

- All walk-ins are numbered sequentially
- Walk-ins are interspersed with scheduled patients based on medical need
- Obtain purpose of visit and vitals
- Print PCC+ for walk-ins

- Electronically request medical record for walk-ins; Medical Records staff delivers to clinic
- Update EHR notes, if using EHR

Registration

- While patient sits in waiting room, obtain name, medical record number, and date of birth.
- While nurse examines patient, verify insurance electronically
- Update demographics
- Complete any needed forms
- Establish new charts
- Provide new applications for those without insurance
- Copy new insurance cards (copies kept in notebook in Business Office)
- Refer patients to Benefit Coordinator
- Patient returns to waiting room

Pediatric, Non-EHR

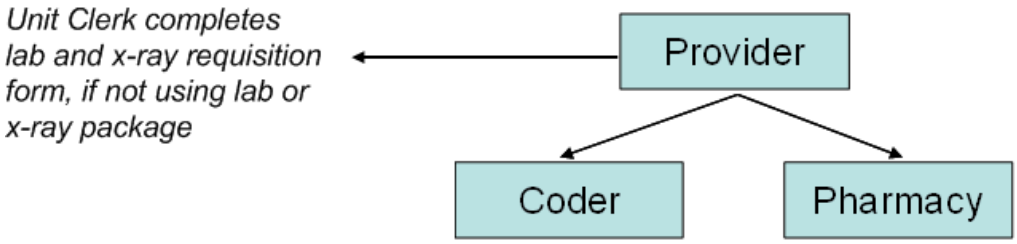


Figure 18: Pediatric process, Non-EHR

Provider

- Perform Clinical exam and provide care
- Document PCC+ or PCC
- Order lab, x-ray, and/or pharmacy on PCC or PCC+
- If pharmacy not ordered, medical record and PCC+ goes to coder

Coder

- Review PCC+ for completeness
- Code where provider only provided written information
- Discuss questions directly with the provider

- Obtain and enter verbal changes from provider
- Change coding to comply with documentation
- Enter vitals, codes, health factors, supplies data
- Send Medical record with PCC+ (initial information entered) to Medical Records

Pharmacy

- Medical record and PCC+ hand carried by staff to pharmacy
- Scan PCC+ for completeness
- Review orders, medical records and lab information
- Enter into Point-of-Sale
- Fill script
- Counsel and educate patient
- Medical record with PCC+ to Medical Records

Pediatric, EHR

Figure 19: Pediatric process, EHR

Provider

- Perform clinical exam and provide care
- Document notes in HER
- Code Evaluation and Management visit and diagnosis
- Order lab, x-ray, and pharmacy electronically via EHR
- Patient sent to lab, x-ray, or pharmacy after final directions and education by nurse

Pharmacy

- Review orders, medical records, and lab information on EHR
- Enter into Point-of-Sale

- Fill script
- Counsel and educate patient
- Dispense meds

Coder

- Review EHR for completeness
- Code where provider only provided written information
- Questions discussed directly with the provider
- Obtain and enter verbal changes from provider
- Change coding to comply with documentation
- Enter vitals, additional codes, health factors, supplies data

Billing

- Print flagged billable report
- Review codes and randomly toggle to EHR for review of documentation
- Bill manually or electronically
- Follow up on outstanding accounts and rejections
- Has a detailed understanding of pediatric benefits for each insurer

Podiatry

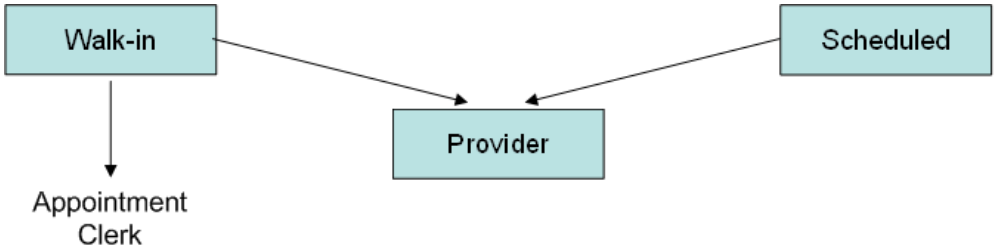


Figure 20: Podiatry process

Note: Because of the uniqueness of this department, it is recommended that coding and data entry be done within the department, or a specialized coder be trained to work with Podiatry.

Walk-in

- Patient presents at Central Registration or Podiatry Registration
- Patient signs in and completes a walk-in form

- Provider reviews either medical record or EHR to determine if patient will be seen between scheduled appointments or will need to schedule an appointment in the future

Scheduled

- Patient checks in at Central Registration or Podiatry Registration
- Demographic and insurance information updated
- Forms completed, if needed
- Insurance card copied, if needed
- Insurance eligibility verification done

Provider

- Complete visit
- Document clinical note on PCC, PCC+ or EHR
- Code procedure, visit and diagnosis on PCC or PCC+ or enter information on HER
- Electronically order lab, x-ray and/or pharmacy

Proposed EHR Workflow

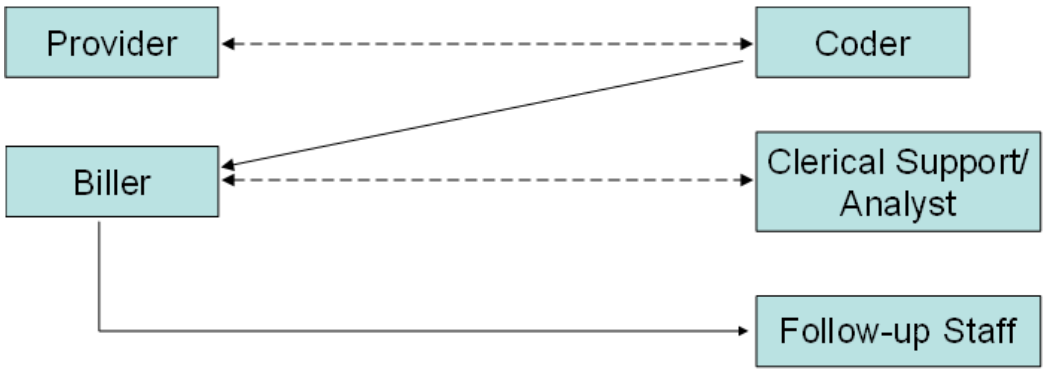


Figure 21: Proposed EHR process

Provider

- Clinical care and treatment
- Electronic order entry - lab, x-ray, pharmacy
- Enter clinical care data in template
- Enter CPT, ICD9, and HCPCS codes, health factors, and other GPRA data
- Document next Appointment

- Patient to lab, x-ray and pharmacy without medical record
- Patient to nurse for education/directions

Coder

- Located in all clinics including Emergency Room
- Validate provider coding in conjunction with provider data entry
- Discuss any codes in question
- Corrections made by provider in system
- Assist with error report resolution

Biller

- Run billable list segregated by insurer (after 48 hours, to allow lab, x-ray, and pharmacy to enter data in system)
- Review EHR documentation (toggle) for
- Clarification of orders
- Questionable codes
- Random Sampling
- Merge lab, x-ray or pharmacy only visits
- Bill electronically or manually dependent on insurer

Clerical Support/Analyst

- Review and correct error report for clinic
- Review and correct rejection report for pharmacy (non-clinical)
- Sort and mail manual insurer forms

Follow-up Staff

Follow up on rejections (medical and pharmacy)and researches insurer requests